The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-698-7032 or visit members.cfhp.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cfhp.com or call 1-877-698-7032 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** individual / **$0** family	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$50** per person for prescription drug expenses. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,550** person / **$13,100** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cfhp.com or call 1-877-698-7032 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	----------None----------
	Specialist visit	$40 copay/visit	Not Covered	----------None----------
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance/test	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$100 copay plus 20% coinsurance/test	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cfhp.com	Generic drugs	$10 copay/prescription (maintenance) $10 copay/prescription (non-maintenance) $30 copay/prescription (mail order or extended day supply)	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Preferred brand drugs	$35 copay/prescription (non-maintenance) $45 copay/prescription (maintenance) $105 copay/prescription (mail order or extended day supply)	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred brand drug and the generic drug.
	Non-preferred brand drugs	$60 copay (non-maintenance) $75 copay (maintenance) $180 copay (mail order or extended day supply)	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred brand drug and the generic drug.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	If purchased through a pharmacy, the pharmacy benefit applies, otherwise, covered as a medical benefit	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay plus 20% coinsurance	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% coinsurance	Not Covered	----------None----------
If you need immediate medical attention	Emergency room care	$150 copay plus 20% coinsurance	$150 copay plus 20% coinsurance	If admitted, copay is applied to inpatient hospital copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------None----------
	Urgent care	$50 copay plus 20% coinsurance	Not Covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/day copay per admission plus 20% coinsurance	Not Covered	$750 copay max per admission. $2,250 copay max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% coinsurance	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Not Covered	----------None----------
	Inpatient services	$150/day copay per admission plus 20% coinsurance	Not Covered	$750 copay max per admission. $2,250 copay max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: $25 PCP copay; $40 specialist copay	Not Covered	No charge for network prenatal office visits or obstetrician delivery.
	Childbirth/delivery professional services	No Charge	Not Covered	----------None----------
	Childbirth/delivery facility services	$150/day copay per admission plus 20% coinsurance	Not Covered	$750 copay max per admission. $2,250 copay max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Rehabilitation services	20% coinsurance without office visit, $40 plus 20% coinsurance with office visit	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Habilitation services	20% coinsurance	Not Covered	----------None----------
	Skilled nursing care	20% coinsurance	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Durable medical equipment	20% coinsurance	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Hospice services	20% coinsurance	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If your child needs dental or eye care	Children's eye exam	$40 copay/visit	Not Covered	Limit of one routine exam per plan year per person.
	Children's glasses	Varies, $125 allowance	Not Covered	Limit of one pair per every 24 months per person.
	Children's dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Artificial insemination
- Bariatric surgery
- Cosmetic surgery
- Dental check-up
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal comfort items
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids
- Private duty nursing
- Routine eye exams

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Community First Health Plans at 1-877-698-7032, or members.cfhp.com; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or www.dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565, or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax 1-512-475-1771
Web: http://www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-698-7032.

Vietnamese (Tiếng Việt): Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.1-877-698-7032

Korean (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-698-7032 번으로 전화해 주십시오.

Arabic (العربية): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن المساعدة اللغوية المجان لك تتوافر. اتصل برقم 1-877-698-7032

Urdu (اُردُو): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی مفت خدمات میں دستیاب ہیں۔ کال 1-877-698-7032

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-698-7032

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-698-7032

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-698-7032

Hindi (हिंदी): ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-877-698-7032

Farsi (فارسی): توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی صورت رایگان به شما برای تماس با 1-877-698-7032

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-877-698-7032

Gujarati (ગુજરાતી): ચુ ના: જો તમેજરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટઉપલબ્ધ છ. ફોન કરો 1-877-698-7032

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-877-698-7032

Japanese (日本語): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-698-7032

Lao (ພາສາລາວ): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ1-877-698-7032

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment and coinsurance** **$150/day copay + 20% coinsurance**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$10,284**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment and coinsurance** **$150/day copay + 20% coinsurance**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,877**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,000
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,510**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment and coinsurance** **$150/day copay + 20% coinsurance**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,447**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$30
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$430**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.